

Agency:
Agreement Number:

Fiscal Year:

Adolescent Family Life Program (AFLP) Scope of Work (SOW)

1. Service Overview

The Agency agrees to provide to the Department of Public Health the services in this Scope of Work. As defined in the implementing statute in Health and Safety Code Sections 124175, 124180, and 124185, the purpose of the AFLP is to address the social, medical, educational, and economic consequences of adolescent pregnancy by (1) establishing local networks to provide necessary services to pregnant and parenting teens and their children, and (2) providing case management services focused on achieving the following goals:

- Improve the health of the pregnant and parenting teen, thus supporting the health of the baby
- Improve high school graduation rates for pregnant and parenting teens
- Reduce repeat pregnancies for pregnant and parenting teens, and
- Improve linkages and create networks for pregnant and parenting teens and their child(ren)

The statute also requires the AFLP to assess client needs and refer clients to services including comprehensive prenatal care, medical care, psychological and nutritional counseling, maternity counseling, adoption counseling, academic and vocational programs, day care, and substance abuse prevention, intervention, and counseling. Each AFLP shall also assure program integrity and maintain a data base to measure outcomes.

The AFLP program is part of the Division's strategy to achieve the following Division priorities identified by the federally required Title V 5-year Needs Assessment for the adolescent pregnant and parenting population the AFLP serves:

- Improve maternal health by optimizing the health and well-being of girls and women across the life course.
- Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.
- Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.
- Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.
- Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.
- Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.
- Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.

The development of this SOW was also guided by the three core public health functions of assessment, policy development, and assurance, the Ten Essential Services of Public Health, the Spectrum of Prevention, the Life Course Perspective, the Socioecological Model, and the Social Determinants of Health.

AFLPs are also required to comply with requirements stated in the AFLP Program Policies and Procedures Manual and the MCAH Fiscal Policies and Procedures Manual such as attending statewide meetings, submitting Agreement Funding Applications, submitting timely invoices and Lodestar data, and completing Annual and Quarterly Reports.

All activities in this Scope of Work shall take place within the fiscal year. The measures marked with * will be calculated by Branagh Information Group from Lodestar data in a Scope of Work report from data in Lodestar data forms, which include Intake, Status Change, Follow Up Form, Service Matrix, Additional Outcomes, Pregnancy Outcome, Freecode Forms. It is essential that agency staff complete these forms accurately and completely.

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2. Service Location

The services shall be performed at various Agencies throughout California.

3. Service Hours

The services shall be provided during normal Agency working hours, excluding national holidays.

4. Project Representatives

The AFLP representatives and contacts during the term of this agreement will be:

California Department of Public Health Maternal, Child and Adolescent Health Division Program Allocations, Integrity and Support Branch Contract Manager: 1615 Capitol Avenue, MS 8305 PO Box 997420 Sacramento, CA 95899-7420 Telephone: Fax:	Agency Name: Agency Contact: Agency Address: City, State, Zip: Telephone: Fax: Email:
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Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

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5. Allowable Informal SOW Changes

- A. The AFLP Agency or the State may propose informal changes or revisions to the activities, tasks, deliverables and/or performance time frames specified in the SOW provided such changes do not alter the overall goals and basic purpose of the agreement.
- B. Informal SOW changes may include the substitution of specified activities or tasks, alteration or substitution of agreement deliverables and modifications to anticipated completion/target dates.
- C. Informal SOW changes processed hereunder shall not require a formal agreement amendment, provided the AFLP Agency's annual budget does not increase or decrease as a result of the informal SOW change.
- D. Unless otherwise stipulated in this agreement, all informal SOW changes and revisions are subject to prior written approval by the State.
- E. In implementing this provision, the State may provide a format for the Agency's use to request informal SOW changes. If no format is provided by the State, the Agency may devise its own format for this purpose.

6. Performance Requirements

- A. In accordance with AFLP Standards, AFLP Agency will provide, at a minimum, the following case management Months of Service (MOS) to eligible adolescents and their children who are not enrolled in Cal-Learn for fiscal year(s):

_____ AFLP MOS for the budget period of 07/01/10 through 06/30/11

If this SOW is for multiple years, please list additional years below:

- B. For each fiscal year of the contract period, the Agency shall submit the deliverables identified below. With the exception of the Management Information System (MIS) Data, the LodeStar program, all deliverables shall be submitted to the Maternal, Child and Adolescent Health (MCAH) Division in accordance with the AFLP Policies and Procedures Manual and postmarked no later than the due date. The LodeStar Data shall be submitted to the current MIS contractor by the date specified below.

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9/8/11

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Deliverables for each FY

Due Date for each FY

Annual Progress Report and Form 5

Aug. 15

MOS **Quarterly** Report and
Quarterly Report Cover Sheet

Oct. 31, Jan. 31, Apr. 30, July 31

Caseload Analysis **Quarterly** Report and Form 4

Oct. 31, Jan. 31, Apr. 30, July 31

Form 6 (**Quarterly**)

Oct. 31, Jan. 31, Apr. 30, July 31

MIS Data (content of previous month)

7th and/or 17th of each month for electronic submission

7. See the following pages for a detailed description of the services to be performed.

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Goal 1: Improve linkages and create networks for pregnant and parenting teens and their children

Outcome Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures to be Reported in the Annual Report or more frequently where indicated	
		Process Measures	Outcome Measures
1.1 AFLP will assess local needs, and develop and maintain a comprehensive, culturally appropriate local network of teen friendly supportive services	1.1.1 Identify and monitor local trends in teen pregnancy and parenting outcomes, including disparities, and social determinants.	1.1.1 List and briefly describe local trends in teen pregnancy and parenting outcomes, including disparities and social determinants.	
	1.1.2 Identify and monitor local geographic areas or population groups that have insufficient access to health and human services for pregnant and parenting teens. Identify high risk groups and areas.	1.1.2 List and briefly describe: <ul style="list-style-type: none"> • Geographic areas or population groups that have insufficient access to health and human services for pregnant and parenting teens. • Any activities that have specifically addressed these gaps and the associated outcomes. 	
	1.1.3 Identify community agencies and other service providers for pregnant and parenting teens and work toward developing documented agreements (e.g., MOUs, letters of support or agreement) for referral with at least the following: <ul style="list-style-type: none"> • Local MCAH Program (for CBOs) • Family PACT providers • CPSP providers • WIC • CalLearn • Cal SAFE 	1.1.3 a. Complete the table in the Annual Report to describe services available to clients and type of agreement for referral. b. Describe the relationship with the local MCAH program c. Describe venues where case management services are delivered to clients, location of offices, and model of service delivery (group, individual, face to face, telephone, combination) (500 word limit)	1.1.3 Identify service gaps and changes in the provider network during the reporting period. Describe the impact of changes or gaps on the AFLP population and strategies to address.

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		Process Measures	Outcome Measures
	<ul style="list-style-type: none"> • Primary care providers • Child care and development services • Local schools or education services, including migrant education where appropriate Other resources could include: <ul style="list-style-type: none"> • Psychological counseling • Social services • Vocational programs • Emergency support • Housing • Legal Assistance • Substance Abuse Prevention • Adoption Counseling • Parenting Classes • Home Visiting Programs 		
1.2 Improve local systems of care through collaboration designed to establish, sustain and enhance comprehensive systems of care for pregnant and parenting teens and their children.	1.2 Participate in at least one collaborative, coalition, network, etc., that develops products or strategies that address unmet needs and promote increased local access to health and human services for pregnant and parenting teens and their children.	1.2 Submit Collaborative Form to document participation in at least one and not more than 3 AFLP collaboratives and coalitions that address unmet needs and improve access to health and human services: Maintain in AFLP Agency network coordination documentation, summaries, and/or minutes of meetings attended.	1.2 Collaborative Form submitted in Process will document objectives and accomplishments and include a description of the collaborative's impact on the local system of care for pregnant and parenting teens. List products developed and outcomes of dissemination.

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		Process Measures	Outcome Measures
1.3 Improve community knowledge of AFLP services and identify potential clients by conducting outreach activities	1.3 AFLP will conduct outreach activities to high risk groups, areas, and community agencies and other service providers to ensure that appropriate and eligible clients are identified, referred to the program and enrolled or placed on a waiting list	1.3 Describe outreach activities and number and sources of clients, community groups, and other service providers contacted.	1.3 State number of referrals from outreach activities by source (client, community group, and other service providers) as described under "process measure". *
1.4 Clients will obtain health insurance.	1.4 Make referrals and assist clients to enroll in Healthy Families, Medi-Cal, Access for Infants and Mothers (AIM) and other low cost/no cost health insurance programs for health care coverage	1.4 Provide the following information: The number of clients and their children receiving referrals to Medi-Cal.*	1.4 Report: a. Number and percent of adolescent clients with health insurance at intake* b. Number and percent of adolescent clients with health insurance at last follow up* c. Number and percent of index children with Medi-Cal *
1.5 Client will access needed services for herself and her child	1.5 CMs will work with clients to assure that clients and children receive linkages to services. CMs will educate client to understand the importance of well child visits and immunizations.		1.5: Report the following: Percent of clients and index children who needed and received services* Attach Service Matrix report specific to agency
1.6 Client will develop a supportive relationship with a stable, caring adult outside of AFLP	1.6 CMs will encourage clients to identify a stable, caring adult outside of AFLP. This could include improving relationships with parents, involvement with community groups or faith communities, or educational institutions.	1.6 Describe the process to incorporate this objective into case management activities.	1.6 Developmental

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Goal 2: Improve the health of the pregnant or parenting teen, thus also supporting the health of the index child

Outcome Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures Report items below in the Annual Report or more frequently where indicated	
		Process Measures	Outcome Measures (Forms)
2.1 Clients will have healthy nutrition and healthy weight.	2.1 Refer to WIC and follow up to encourage linkage Refer to CPSP provider if pregnant and reinforce healthy diet/weight gain. Assist client to develop a goal to achieve or maintain a healthy weight Program policies and activities, including case management activities, will promote and model healthy diet and reinforce healthy nutrition	2.1 List key activities used to promote healthy nutrition and healthy weight.	2.1 Report number and percentage of clients receiving WIC *
2.2 Clients will engage in daily physical activity	2.2 Encourage physical activity daily, at least one hour four times a week, or as allowed by MD if pregnant. Program policies and activities, including case management activities, will promote and model regular and frequent physical activity	2.2 List key activities used to promote physical activity.	2.2 Report average number of days of physical activity per week for clients at last follow up*
2.3 Pregnant clients will receive timely prenatal care in order to maximize their health and deliver a healthy baby.	2.3 Refer to prenatal provider, use CPSP provider when available Identify and address barriers to keeping appointments.	2.3 Describe success/challenges in linking to CPSP and other prenatal providers.	2.3 (PO) Report the number and percent of pregnant clients who: a. Received prenatal care * b. Had a LBW baby (<2500g) * c. Had a pre term baby <37 wks* d. Had an LGA baby (>4000g or 8#-13oz.)*
2.4 Clients will initiate and continue breastfeeding	2.4 Encourage breastfeeding	2.4 List activities used to promote breastfeeding.	2.4 Report number and percent of clients who did any breastfeeding*
2.5 Clients will not use tobacco	2.5 Assess each client for tobacco use using self-report and/or validated screening tool. Advise to quit or decrease tobacco use. Refer to tobacco quit line, other treatment as appropriate,	2.6 Briefly describe activities to screen and refer clients to tobacco cessation.	2.5 a. Report number and percent of clients who were using tobacco at intake* b. Percent of clients who were smoking at last follow up.*
2.6 Clients will not use	2.6 Assess each client for alcohol or	2.6 Describe key challenges related to	2.6 Report number and percent of clients

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Goal 2: Improve the health of the pregnant or parenting teen, thus also supporting the health of the index child

Outcome Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures Report items below in the Annual Report or more frequently where indicated	
		Process Measures	Outcome Measures (Forms)
alcohol or other drugs	other drug use using self-report and/or validated screening tool. Advise to quit or decrease alcohol or other drug use. Refer to treatment for alcohol or other drug use	AOD use among clients.	who a. Used alcohol in the 6 months before intake * b. Used alcohol in the 6 months before last follow up* c. Used drugs in the 6 months before intake* d. Used drugs in the 6 months before last follow up*
2.7 Non pregnant clients will receive primary preventive health care	2.7 Discuss with each client the importance of receiving primary preventive health care to prevent illness and identify and address health conditions early (for example, STIs, chronic conditions, pregnancy related conditions) Inform clients about importance of chlamydia screening (per CDC rec to annually screen all youth ≤ 25) and encourage to request testing by provider Identify and address barriers to clients receiving primary preventive health care	2.7 Briefly describe successes and challenges in clients obtaining primary preventive care.	2.7 Report the number and percent of clients who received primary preventive health care as indicated by service matrix form.*
2.8 Clients will demonstrate knowledge of normal child development and appropriate parenting skills	2.8 Observe client/child interactions. Provide child development and parenting education. This could include use of validated early childhood developmental screening tools (e.g. ASQ, ASQ SE) and must include identification of a source of preventive and primary care for the client and her child. Provide anticipatory guidance and education regarding importance of developmental screening and well child visits.	2.8 State how AFLP implements this objective. Identify assessments or other curricula used and usual types of referrals.	2.8 Service Matrix Report.

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Outcome Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures Report items below in the Annual Report or more frequently where indicated	
		Process Measures	Outcome Measures (Forms)
	Model appropriate parenting skills and refer to parenting classes or other resources.		

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Goal 3: Improve high school graduation rates for pregnant and parenting teens.

Outcome Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures Report items below in the Annual Report or more frequently where indicated	
		Process Measures	Outcome Measures (Forms)
3.1 All clients will set and achieve a goal to complete high school or equivalent.	3.1 Case managers will work with all clients to develop and execute a plan for the client to complete high school or the equivalent. CM will communicate with school staff responsible for tracking the client's academic progress (e.g. high school counselor, special education teacher, or migrant education program) routinely, at least biannually and note in ISP. Identify and address barriers to attending and completing high school	3.1 List and briefly describe the top three barriers to clients completing high school and strategies to address barriers.	3.1 Report the number and percent of clients who a. Were attending school or had graduated or the equivalent, and total.* b. Have an educational goal *
3.2 Parenting Clients will have a reliable source of quality child care to enable them to attend school.	3.2 CM will help client identify and address barriers to obtaining reliable, high quality child care.	3.2 List and briefly describe the top three barriers to clients obtaining child care and strategies to address.	3.2 Report number and percent not in school because of child care barrier*
3.3 Clients will have reliable transportation to school	3.3 CM will help client to identify and address barriers to obtaining reliable transportation to school	3.3 List and describe the top three barriers to clients having transportation to school and strategies to address.	3.3 Report number and percent of clients not attending school because of transportation barrier. *
3.4 Clients who have graduated from high school will enroll in postsecondary education or training or will be employed	3.4 CM will assist clients to develop and execute a plan for postsecondary education or training or employment (see next objective)after high school completion.	3.4 List and describe the top three barriers to clients enrolling in postsecondary education or training and strategies to address. Identify opportunities for policy development, program planning and collaboration.	3.4 Report the number and percent of clients who have graduated high school that are enrolled in postsecondary education or vocational school.*
3.5 Clients who have graduated from high school and are not enrolled in postsecondary education training will be employed	3.5 CM will assist clients who do not wish to pursue postsecondary education or training to develop and execute a plan to obtain employment after high school completion	3.5 List and describe the top three barriers to clients obtaining employment and strategies to address. Identify opportunities for policy development, program planning and collaboration.	3.5 Report the number and percent of clients who have graduated high school and are employed. *

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Goal 4: Reduce repeat pregnancies in pregnant and parenting teens.

Outcome Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures Report items below in the Annual Report or more frequently where indicated	
		Process Measures	Outcome Measures (Forms)
4.1 Clients who are not pregnant and are sexually active will: <ul style="list-style-type: none"> • Always use contraception, • Use long acting contraceptives • Not have a repeat pregnancy while in the program. • Use condoms to prevent STIs 	4.1. Refer to Family PACT/ primary care provider. Identify and address barriers to correct and consistent use of contraception. Encourage clients to use long acting contraceptives Document client pregnancies Encourage clients to use condoms to prevent STIs. Educate on family planning as possible within the scope of training and licensure of the CM.	4.1 Describe the top three barriers to clients using contraception and strategies to address.	4.1 Report Number and Percent of sexually active nonpregnant clients who; <ul style="list-style-type: none"> •are always using contraception * • Are using long acting contraceptives (3,6,7)* Report number and percent of clients who <ul style="list-style-type: none"> • had a repeat birth while in the program (all female clients)* • Are using condoms* • Are using condoms with another method *
4.2 Clients will verbalize characteristics of healthy relationships and how to recognize and respond to reproductive coercion and birth control sabotage (RC/BCS).	4.2 AFLP will integrate information about RC/BCS into the SID and train CMs to provide information to clients. Screen clients for RC/BCS. Provide resources (Safety cards, Web sites) on recognizing and addressing this. Refer clients to providers to obtain coercion resistant birth control methods and counseling. Provide emotional support Maintain and train on local policy and procedure for mandatory reporters.	4.2 a. Report number of clients who received information on reproductive coercion and birth control sabotage. * Describe process to integrate information on reproductive coercion and birth control sabotage into case management. b. Report number of clients referred for "coercion resistant" birth control methods and counseling.* Provide compelling anecdotal stories when available.	4.2 a. Report number and percent of clients who state they feel safe in their relationship with their partner/other parent at intake.* b. Report number and percent of clients who state they feel safe in their relationship with their partner/other parent at last follow up.*

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Goal 5: AFLP will maintain program and fiscal management capability to administer the program as required by the AFLP Program Policies, Procedures and Scope of Work and will assure staff competency, program integrity, and data completeness.

Outcome Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures Report items below in the Annual Report or more frequently where indicated	
		Process Measures	Outcome Measures (Forms)
5.1 AFLP will maintain program and fiscal management capability and will demonstrate that it is conducting AFLP activities as required in the AFLP Policies and Procedures, Scope of Work and Program and Fiscal Policies and Procedures.	5.1 <ul style="list-style-type: none"> • Annually review, revise and enhance internal policies and procedures for delivering services to clients to prioritize the highest risk clients (Entry Criteria) • Meet the MOS. • AFLP will maintain a client to case manager ratio of no more than 50 clients per case manager. • Submit AFA and Annual Report timely • Collect and input monthly Follow Up, Service Matrix and Additional Outcomes forms that are due. 	5.1 Submit Form 2D, Entry Criteria Transmittal annually with Annual Report due August 15 for the previous fiscal year.	5.1 <ul style="list-style-type: none"> a. Report number of clients and MOS for the year along with percent of allocation delivered (MOS and Caseload Analysis Report). * b. Submit the MOS and Caseload Analysis Report and AFLP/Cal-Learn Personnel List quarterly. * c. Report the percentage of clients who have completed Follow Up Forms when the index child is six months old* d. Report the percentage of clients who have Service Matrix and Additional Outcome forms with the Follow Up Form. *
5.2 AFLP will maintain and increase staff competency	5.2 Identify staff training needs <ul style="list-style-type: none"> • Provide or support staff training • AFLP Director will attend statewide meetings. • AFLP Director will conduct self-assessment of Core Competencies for Providers of Adolescent Sexual and Reproductive Health using the ASHWG (CA Adolescent Sexual Health Workgroup) tools and require supervisory staff to do so. • Develop plan for conducting this assessment for case managers. 	5.2 List gaps in core competencies identified and trainings and educational events for AFLP staff to address these gaps. <ul style="list-style-type: none"> • Describe plan for conducting ASHWG core competency assessment for case managers. • List training needs that you recommend for consideration at AFLP Statewide Meetings. 	5.2 State the number of staff attending each training and describe staff response to each training. Report AFLP Director attendance at statewide meetings.

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5.3 AFLP director will assure that CMs conduct intake, comprehensive baseline assessment, develop an Individual Service plan, provide appropriate referrals, and conduct other elements of case management defined in the Standards, Policies and Procedures.	5.3 AFLP will conduct monitoring and evaluation of client documentation for: <ul style="list-style-type: none"> • Comprehensive Baseline Assessment within 30 days of consent—includes HV. • Individual Service Plan within 60 days of consent • monthly face to face client contact • Quarterly Home Visit • quarterly contact with collaterals (i.e. parents, teachers, counselors) and service providers; • identification of barriers to services and emerging or changing client needs, • evaluation of client use of services using feedback from client, collateral, and service providers. • Quarterly client reassessment and update and revision, if needed, of service plans Monitor above measures in a quarterly random sample of 25 charts or 10%, whichever is lower, and routinely implement QI activities to address measures not meeting the standard. Consider addressing one deficient measure per quarter.	5.3 State number and percent of clients that: <ol style="list-style-type: none"> a. received a Comprehensive Baseline Assessment within 30 days of enrollment* b. received a Home Visit within 30 days of enrollment* c. received monthly face to face contact* d. had an Individual Service Plan within sixty days of enrollment e. case manager made quarterly contact with collaterals or service providers. * f. Received a reassessment subsequent to the initial Assessment. * g. received a case review to assure compliance with AFLP Standards, Policies and Procedures (narrative). Briefly describe QI activities and which standard(s) have been addressed.	5.3 Describe the outcome of the QI plan.

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